| Form **13704** (August 2005) | Department of the Treasury–**Internal Revenue Service**<br>**HEALTH COVERAGE TAX CREDIT REGISTRATION UPDATE FORM** | **OMB Number 1545-1954** |
|---|---|---|

Use this form to make updates to your HCTC registration. As a participant in the advance Health Coverage Tax Credit (HCTC) Program, you are responsible for updating your Qualified Health Plan or policy information, and information about your Qualified Family Member(s) or their Qualified Health Plan(s) or policies. Failure to provide the HCTC Program with accurate information will result in the termination of your participation in the advance tax credit program.

**Instructions:**

1. Keep a blank copy of this form in your personal records for future use. This form can also be found at www.irs.gov (IRS Keyword: HCTC).
2. Answer all of the questions by typing or printing your answers legibly in black ink.
3. Enter "N/A" in any field that does not apply to you or to your qualified family member(s).
4. Complete Part IV, Update Information about Your Qualified Health Plan, on page 2.
5. Sign and date this form on page 2, Part V.
6. Keep a copy of this completed Registration Update Form and all required documents for your personal records.
7. Mail the completed form and required documents to: **HCTC Processing Center**
   P.O. Box 4700
   Waterloo, IA 50704-9925

## Part I: Provide Information about You

**YOUR INFORMATION**

| 1. SSN or TIN | 2. Date of Birth (mm/dd/yyyy) | | |
|---|---|---|---|
| 3. Last Name | 4. First Name | 5. Middle Initial | 6. Suffix (Jr., II) |
| 7. Mailing Address | 8. City | 9. State | 10. Zip Code |
| 11. Telephone Number (include area code) | | 12. Check Here if Address or Phone Have Changed ☐ | |

**Note:** You must also provide any changes to your mailing address to the agency that reports you as being eligible for the HCTC, either your local State Workforce Agency (SWA) or the Pension Benefit Guaranty Corporation (PBGC), so that there is no interruption in your benefits or health insurance.

**ELIGIBILITY REQUIREMENTS**

Are **all** of the following statements true? Mark each statement to indicate that it is still true for your situation. *If one or more of the following are not true you are not currently eligible for the HCTC. Do not submit this form.*

- ☐ You are an eligible trade adjustment assistance (TAA) recipient, alternative TAA (ATAA) recipient; or you are at least 55 years of age and a PBGC pension recipient.
- ☐ You are covered by a qualified health insurance plan.
- ☐ You are **not** entitled to Medicare. You are **not** enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP).
- ☐ You are **not** enrolled in the Federal Employees Health Benefits Program (FEHBP) or eligible to receive benefits under the U.S. military health system (TRICARE/CHAMPUS).
- ☐ You are **not** imprisoned under federal, state, or local authority.
- ☐ You are **not** covered by any health insurance plan for which your former employer, or spouse's employer, pays more than 50% of the premium.

## Part II: Indicate What to Update in Your HCTC Registration

**CHECK ALL THAT APPLY**

- ☐ Add or Remove a Qualified Family Member to/from Your Registration or Qualified Health Plan
- ☐ Change To a New Qualified Health Plan *Start Date of Coverage:*
- ☐ Update Information about Your Current Qualified Health Plan (e.g., Group/Policy Number, Change in Premium)
- ☐ Switch Your Registration From TAA to PBGC
  *Contact the HCTC Customer Contact Center to switch your registration from TAA to ATAA.*
- ☐ Switch Your Registration From ATAA to PBGC
- ☐ Re-Activate Your Account

## Part II (Continued)

**BRIEFLY DESCRIBE UPDATES**

## Part III: Update Information about a Qualified Family Member

Photocopy this page before filling it out if you have more qualified family members than the space below allows. Use Part IV below to provide health plan information for qualified family members with their own qualified health plan.

| **INFORMATION FOR QUALIFIED FAMILY MEMBER** | | Add ☐ | Remove ☐ |
|---|---|---|---|
| 1. SSN or TIN | 2. Date of Birth (mm/dd/yyyy) | 3. Relationship ☐ Spouse ☐ Child ☐ Other | |
| 4. Last Name | 5. First Name | 6. Middle Initial | 7. Suffix (Jr., II) |

## Part IV: Update Information about Your Qualified Health Plan

Include proof of insurance (e.g., a current invoice) for each qualified health plan when you submit this form. Refer to Steps 2 and 3 in the HCTC Program Kit for examples of exceptions and acceptable forms of proof of insurance. If you have additional questions, visit www.irs.gov (IRS Keyword: HCTC) or contact the HCTC Customer Contact Center at 1-866-628-HCTC (4282), TDD/TTY 1-866-626-4282.

| **YOUR QUALIFIED HEALTH PLAN INFORMATION** | | |
|---|---|---|
| 1. Member ID* | 2. Group ID* | 3. Policy ID* |

| 4. Policyholder's Name (Last, First, Suffix) | 5. Policyholder's SSN or TIN |
|---|---|
| 6. Total Number of People (Qualified and Non-Qualified on This Health Plan) | 7. Number of Non-Qualified People on This Health Plan |

| 8. Total Premium | 9. Total Premium Paid for Non-Qualified Family Members | 10. Total Premium Paid Using MSA or HSA | 11. Total Premium Paid for All Exceptions |
|---|---|---|---|
| | | | |

** You must complete at least one of these fields in order for your HCTC Registration Update Form to be processed.*

If your qualified health plan is COBRA you must also provide the following information:

| **FORMER EMPLOYER AND COBRA INFORMATION** | | |
|---|---|---|
| 1. Former Employer's Name | 2. Former Employer's Telephone Number (include area code) | |
| 3. COBRA Start Date | 4. COBRA End Date | Check Here if a Lifetime Benefit ☐ |

## Part V: Confirm That You Are Still Eligible

Under penalties of perjury, I declare that the information furnished on this form with regard to myself and to any qualified family member(s), and any attachments to it, are true, correct, and complete. I understand that a knowing and willfully false statement on this form can result in my disqualification from participating in the advance tax credit program. By signing, I also agree to allow the IRS to share my eligibility status and payment information with my health plan administrator.

| **Signature (sign in black ink)** | **Full Name (type or print legibly)** | **Date Signed** |
|---|---|---|
| | | |

**PAPERWORK REDUCTION ACT NOTICE.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. Your response is voluntary. You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by code section 6103. The estimated average time to complete this form is 15 minutes. If you have comments concerning the accuracy of this time estimate or suggestions for making this form simpler, we will be happy to hear from you. You can write to the Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, Washington, DC 20224.
PRIVACY ACT STATEMENT. The following information is provided to comply with the Privacy Act of 1974 (P.L.93-579). All information collected on this form is required under the provisions of 31 U.S.C. 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data, by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearing House Payment System.